

Index to Volumes 5 and 6, with Abstracts

This Index provides a guide to Articles, Comments, and featured Book Reviews published in Volumes 5 and 6 of the *American Journal of Law & Medicine*, covering Vol. 5, No. 1 (Spring 1979); Vol. 5, No. 2 (Summer 1979); Vol. 5, No. 3 (Fall 1979); Vol. 5, No. 4 (Winter 1980); Vol. 6, No. 1 (Spring 1980); Vol. 6, No. 2 (Summer 1980); Vol. 6, No. 3 (Fall 1980); and Vol. 6, No. 4 (Winter 1981). An Index to Volumes 1 and 2 appears in Vol. 3, No. 1 of the *Journal*; an Index to Volumes 3 and 4 appears in Vol. 5, No. 1. The reader is reminded that previous volumes of the *Journal* contain, in addition to Articles and Comments, extensive reference materials providing access to selected medicolegally relevant book releases, court decisions, articles, federal legislative and executive action, professional organizations, resource centers, and periodical publications.

ARTICLES AND COMMENTS

Acford, Joanne P., *Reducing Medicaid Expenditures Through Family Responsibility: Critique of a Recent Proposal*, Spring 1979, 59-79.

The Massachusetts Department of Public Welfare recently proposed a "Family Responsibility Plan" which would impose a financial obligation upon adult children in the state for the nursing-home care of their parents who receive Medicaid. By examining the Massachusetts plan, this Note seeks to evaluate the viability of a concept of family responsibility, under which adult children contribute to the state Medicaid expenses of their medically indigent parents in nursing homes, as a means of combating the increase in state Medicaid expenditures. The Note examines the legal and policy issues raised by the Massachusetts welfare department's plan in particular, and by the concept of family responsibility in general. The author concludes that alternative methods of cost containment, such as positive financial incentives, would be more appropriate mechanisms for reducing state Medicaid expenditures than family—that is, adult child—responsibility plans.

Brant, Jonathan, and Graceffa, John, Rutherford, Privitera, and Chad Green: *Laetrile's Setbacks in the Courts*, Summer 1980, 151-71.

The *Chad Green* case has again focused national and international attention on the unproven cancer remedy known as laetrile. Laetrile has attracted

considerable attention in recent years as a result of claims that it is a non-toxic form of cancer treatment. Twenty-one states have legalized prescription of laetrile within their borders, despite the efforts of the Food and Drug Administration (FDA) to keep laetrile off the market.

The authors examine the claims about laetrile's effectiveness and comment upon scientific tests concerning its efficacy. They maintain that scientific support for the use of laetrile is almost totally absent and that evidence of the dangers of laetrile is substantial. After reviewing the medical evidence concerning laetrile, the authors describe the efforts of laetrile proponents to use the courts as the battleground to legalize laetrile. In early skirmishes, laetrile proponents were successful in opposing the efforts of the FDA; under a constitutional privacy theory several courts upheld the right of competent adults to select laetrile therapy.

Subsequently, however, as the authors demonstrate, the U.S. Supreme Court, in *United States v. Rutherford*, and the California Supreme Court, in *People v. Privitera*, narrowed the federal constitutional privacy right by declining to read into it a right to take laetrile. Finally, the Massachusetts Supreme Judicial Court, in the *Chad Green* case, considered the question of laetrile's toxicity to a recipient of the drug.

The authors discuss the interrelationship among the three cases. They argue that the overwhelming proof in *Chad Green* that laetrile is harmful undermines any statutory or constitutional claims supporting legalization, because such claims assume that even if laetrile is not truly therapeutic outside of the placebo effect, it is not toxic. In light of the three decisions, the authors conclude that supporters of laetrile should not expect that the courts will be sympathetic to future legal efforts to approve or to permit use of laetrile therapy.

Buchanan, Allen, *Medical Paternalism or Legal Imperialism: Not the Only Alternatives for Handling Saikewicz-type Cases*, Summer 1979, 97-117.

In 1977, the Supreme Judicial Court of Massachusetts held in the *Saikewicz* case that the probate court is the proper tribunal for making decisions whether to give or to withhold "life-prolonging treatment" for terminally ill incompetent patients. This ruling provoked debate in the medical and legal communities. Dr. Arnold Relman, Editor of *The New England Journal of Medicine*, argues that *Saikewicz* encroaches on existing sound medical practice and requires decision-making machinery that is impractical and inhumane. Relman contends that treatment decisions for terminally ill incompetents in *Saikewicz*-type cases should be made by the physician in consultation with the patient's family. Law professor Charles Baron, in contrast, defends *Saikewicz*'s judicialization approach, arguing that such decisions must be made in an adversary framework that approximates the ideal of the rule of law.

In the present Article, Professor Buchanan argues that Relman's criti-

cism of *Saikewicz* rests on a defective, medical paternalist view of the physician-patient relationship, and that Baron's support of *Saikewicz* is based on an unjustifiable, legal imperialist view of decision making for incompetents. In Buchanan's view, Relman's approach fails to distinguish appropriately between the making of medical judgments and the making of moral judgments and wrongly assumes that the patient's family typically cannot understand the elements of the decision, while Baron's approach unjustifiably extends the sphere of the legal process by ignoring the special moral relationship that usually exists between the family and its incompetent member.

Buchanan proposes an alternative decision-making approach that he believes incorporates the merits, while remedying the defects, of both Baron's and Relman's approaches. The alternative is based on three propositions. (1) The proper *presumption* in *Saikewicz*-type cases is that the family of an incompetent is to make decisions concerning treatment. (2) This *presumption* of the family's dominant role in decision making is *defeasible*: protection of the patient's rights requires that decisions be made within a framework that allows vigorous discussion and accountability through impartial review and that provides for legal intervention when necessary. (3) The institutional framework for implementing the features listed in the preceding proposition will rely heavily upon an *ethics* committee that is neither an all-medical prognosis committee nor an administrative agency of the hospital.

Besides evaluating and responding to the Relman and Baron approaches, Buchanan examines the contribution to the *Saikewicz* debate made by law-and-medicine professor George Annas. In essence, Buchanan rejects Annas's argument that, taken together, the *Saikewicz* opinion and the *Quinlan* opinion of the Supreme Court of New Jersey delineate a proper division of medical and legal decision-making responsibility concerning terminally ill incompetents. Buchanan concludes that, contrary to Annas's view, those two cases are not reconcilable.

Canarie, J. David, Jr., *Maldistributed Health Care Services: Restructuring the Current Regulatory System*, Fall 1980, 407-23.

The American health care delivery system currently suffers from a variety of problems; among the most intractable of these is a maldistribution of health care services. This Note focuses on two aspects of this problem: unnecessary hospital beds, and medically underserved populations. The Note also discusses the related issues of hospital cost inflation and inefficient use of limited resources. It then examines the current statutory remedies for these problems, and subjects their effectiveness to a two-tiered test. The Note concludes that the existing mechanisms, while partially effective, ultimately result in a fragmented, uncoordinated, and unsuccessful health care regulatory system. Moreover, the Note suggests not only that the

existing statutes fail to solve the problems they were enacted to correct, but that they actually add to health care inflation and complicate health planning by subjecting the entire health care industry to uncertainty. This Note proposes a comprehensive regulatory approach that will resolve health care imbalances in a manner that avoids the shortcomings inherent in the present system.

Finkelstein, Stan N., and Sapolsky, Harvey M., *Controlling Post-transfusion Hepatitis: A Proposal to Publicize Hepatitis Rates of Transfusion Facilities*, Spring 1979, 1-9.

A federal requirement that donor blood be labelled as either "paid" or "volunteer" took effect on May 15, 1978. A major rationale for requiring such labelling is that physicians, now that they can distinguish between categories of blood, will fear liability for post-transfusion hepatitis resulting from the use of paid blood. Thus, supporters of the labelling requirement hope that it will deter the use of high-risk commercial blood. Some paid blood, however, is not commercial blood and in fact may be safer than volunteer blood. The labelling strategy for hepatitis control, therefore, has negative as well as positive attributes. This Article considers the efficacy of blood labelling as a hepatitis control measure and proposes an alternative strategy—the periodic publicizing of hepatitis rates of facilities that perform transfusions—that, if practiced responsibly, could significantly decrease hepatitis transmission rates.

Gibson, Joan M., and Schwartz, Robert L., *Physicians and Lawyers: Science, Art, and Conflict*, Summer 1980, 173-82.

The relations between physicians and lawyers have deteriorated rapidly over the past several decades, most particularly since the early 70s when the perception that a medical malpractice crisis existed in America became widespread. Some believe that the factors dividing the two professions are linked (1) to professional jealousy, (2) to sometimes conflicting economic interests, or (3) to difficulties in communication, since both professions use many of the same words, or terms of art, but with different intended meanings.

While the authors agree that these factors may have aggravated the problem, they believe that the conflict's real roots are in the very different ways in which physicians and lawyers are trained and in the different epistemologies that each profession has accepted, as a result of which each reasons and solves problems in a manner that not only diverges from but sometimes contradicts the other's. The authors conclude that only as the varying epistemologies begin to converge can physicians and lawyers begin to approach problems in more similar ways, and to discover the underlying compatibility of many of their interests and goals.

Gold, Jay Alexander, *Does the Hyde Amendment Violate Religious Freedom? Harris v. McRae and the First Amendment*, Fall 1980, 361-72.

In *Harris v. McRae*, the recent case in which the U.S. Supreme Court upheld the constitutionality of the Hyde Amendment, the Court for the first time was asked to consider whether antiabortion legislation respects the establishment of religion or violates the free exercise thereof. The Court held that the Amendment did not effect an establishment of religion, and found that the plaintiffs lacked standing to raise the free exercise argument.

The writer explores the questions raised, agreeing with the Court's disposal of the establishment argument. He does find considerable validity in the free exercise challenge, but concludes that the Court as presently constituted is unlikely to accept it. In addition, he believes that the Court, in its treatment of both arguments, either ignored or improperly distinguished earlier cases that supported the plaintiffs.

Horwitz, Eve T., *Of Love and Laetrile: Medical Decision Making in a Child's Best Interests*, Fall 1979, 271-94.

Two recent cases have raised important questions concerning the appropriateness of state intervention in parental choices of unorthodox medical treatment for children with life-threatening conditions. This Note first discusses whether, and if so, when, state intervention in a child's treatment selection by its parents is appropriate, and then analyzes the tests a court should apply in deciding upon an appropriate treatment. The Note recommends a decision-making approach that requires the appropriate state agency to prove, by clear and convincing evidence, that the parents' choice of medical treatment either is directly or is indirectly harming their child. Under this approach, if the state meets its burden of proof the court then must apply the "best interests" test, rather than the "substituted judgment" test, to choose an appropriate medical treatment for the child.

Jones, Nancy Elizabeth, *Termination of Skilled Nursing Facility Medicaid Provider Agreements: Procedural Due Process Requirements*, Winter 1981, 451-93.

When a state Medicaid agency terminates its provider agreement with a skilled nursing facility, federal regulations give the state the option of providing a pretermination evidentiary hearing; they do not, however, require that a state provide such a hearing. If a state chooses not to grant a pretermination hearing, as a number of states have done, federal regulations require: (1) an informal written reconsideration made by the state and submitted to the skilled nursing facility before the effective date of the termination, and (2) a posttermination evidentiary hearing.

This Article argues that a skilled nursing facility has a right under the due process clauses of the fifth and fourteenth amendments of the U.S.

Constitution to an evidentiary hearing before termination of its Medicaid provider agreement. The author claims that a skilled nursing facility's interest in continued receipt of Medicaid reimbursement under its provider agreement is a property interest entitled to constitutional due process protections, and not merely an expectation of economic benefit that does not implicate constitutional due process considerations.

The Article concludes that, except in emergency situations, state Medicaid agencies are constitutionally required to grant a provider a pretermination, rather than a posttermination, evidentiary hearing. This procedure would protect the provider and its patients from the severe effects of an erroneous termination, while furthering the governmental interest in ensuring the health and safety of skilled nursing facility patients. The format for such a hearing should allow for the participation, with the assistance of counsel, of both the skilled nursing facility and its patients.

Lachance, Denise, *In re Grady: The Mentally Retarded Individual's Right to Choose Sterilization*, Winter 1981, 559-90.

In the case of *In re Grady*, the New Jersey Superior Court addressed important issues concerning the propriety of a court's exercise of parens patriae jurisdiction to ratify parents' substituted consent to the sterilization of their mentally retarded child. This Note discusses the genesis of the fundamental right to choose sterilization, its application to mentally retarded individuals, and the adequacy of the procedural framework enunciated in *Grady* to assure that substituted consent by the parents is exercised solely in the mentally retarded individual's "best interests." This Note concludes that, while the *Grady* court properly exercised its parens patriae jurisdiction, the procedural framework enunciated is inadequate. The Note proposes a model that would implement the procedural elements the Note determines are essential to a "best interests" inquiry. The proposal requires: (1) that the individual be adjudicated incompetent; (2) that a guardian ad litem be appointed and required to argue that sterilization is not in the incompetent's "best interests"; and (3) that the court determine, as a question of fact, whether the parents' exercise of substituted consent is in the incompetent's "best interests." The Note also suggests criteria which can be used in making the "best interests" determination, and recommends that "clear and convincing" evidence be required to support the "best interests" standard.

LaDou, Joseph, Mulryan, Lawrence E., and McCarthy, Kevin J., *Cumulative Injury or Disease Claims: An Attempt to Define Employers' Liability for Workers' Compensation*, Spring 1980, 1-28.

The workers' compensation systems of several states have been expanded in recent years to include injuries and diseases caused by cumulative injury

and occupational stress. This expansion has placed a financial burden on the respective systems, on employers, and on consumers, who ultimately must pay the cost of claims through higher priced products or services. This expansion may not be justified from a social perspective, however; extant medical and sociological evidence is not conclusive as to whether occupational-stress injuries or diseases—such as coronary heart disease, hypertension, stroke, and neuropsychiatric illness—are the direct result of stressful work environments. Using the California workers' compensation system as a model, the authors submit that the underlying premises of liability governing the expanded systems should be reassessed based (1) on economic factors, specifically, the increasing costs of workers' compensation; (2) on the capacity of the system to process an ever-increasing number of claims; and (3) on the principle on which workers' compensation systems were established, that of equity between the employer and the employee.

On the basis of these three factors, the authors evaluate three legislative approaches to restructuring the expanded system: presumption of compensability, apportionment of liability, and threshold of compensability. The first recognizes that although certain health problems are related to the workplace, the degree of causation is difficult to prove; under this approach, therefore, causation is presumed, and injury compensated, for all diseases and injuries that the system defines as work-related. The second holds that where a causal relationship between the work and the injury can be proved, the employer nevertheless should be responsible only for that portion of the disability actually caused by the workplace. The third directs that the injured employee be compensated only when a direct causal link between the job and the injury or disease can be proved. The authors recommend that legislators implement this third alternative. For one reason, it is feasible economically; for a second, it would not burden the system or increase litigation; for a third, it is equitable to both employees and employers.

Lewis, Thomas J., *Community Participation in the Certificate-of-Need Process: A Look at Ten-Taxpayer Groups in Massachusetts*, Fall 1979, 215-30.

Certificate-of-need statutes give designated state agencies veto power over investment in health care facilities. Some states have sought to temper the arbitrary character of this power by expanding the opportunities for community input into the certificate-of-need process. Massachusetts, for example, has enacted a statute that allows groups of ten taxpayers to petition for a public hearing on any certificate-of-need application.

Some observers question whether the benefits of taxpayer-group participation are substantial enough to compensate for the delays and abuses that the statute allegedly invites. To help resolve this question, this comment examines historical data on Massachusetts taxpayer groups and on

their activities and assesses the significance of their composition and tactics to the certificate-of-need process.

Although flaws exist in the Massachusetts ten-taxpayer mechanism, in this writer's view it has succeeded partially in making the certificate-of-need process responsive to community opinion. Many groups lack the skills and qualities needed to make constructive use of the ten-taxpayer mechanism. Nevertheless, it serves a valuable purpose by creating a public forum for and by encouraging public participation in the certificate-of-need process, especially by those who might otherwise try to circumvent that process through use of special legislation, of private pressure, or of other similar means.

Mackie, Dustin L., and Biblo, Robert L., *HMO Development: Threat or Opportunity for Hospitals?*, Spring 1980, 29-49.

Many hospitals presently find themselves at a vulnerable stage in their development. The increased efficacy of antibiotics, together with the population's increased life span and decreasing birth rate, have reduced the need for the kind of acute inpatient care that hospitals traditionally have provided. Moreover, hospitals now are feeling pressure from federal and state regulatory agencies to eliminate approximately 20 percent of the nation's acute-care beds. Concurrent with the population's changing health needs and with the increasing regulatory pressure from government, the acute-care hospital also must contend with the advent of a rival medical care delivery organization—the health maintenance organization (HMO)—whose primary goal is to provide quality medical services in a cost-efficient manner. One of the most important ways in which HMOs contain costs is by attempting to reduce significantly the rate of hospitalization of their members, an approach that threatens the very livelihood of some hospitals.

The authors describe five alternative strategies that hospitals can adopt to meet the potential threat of HMOs—filibustering, passive acceptance, direct sponsorship, accommodation, or strong support. They maintain that the latter of these strategies, strong support, places hospitals in the most favorable position to convert the threat of HMO development into an opportunity to build a mutually beneficial relationship.

Marco, Corey H., and Marco, Joni Michel, *Antabuse: Medication in Exchange for a Limited Freedom—Is it Legal?*, Winter 1980, 295-330.

Recidivism among alcohol offenders—drunken drivers in particular—has led courts to experiment with programs that attempt to rehabilitate problem drinkers. One such program, in El Cajon, California, offers defendants the choice of going to jail or of submitting to a year of treatment with Antabuse, a potent drug that reacts with alcohol to produce intensely painful physical symptoms. In addition, Antabuse subjects the recipient to the risk of toxic side effects.

According to the authors, the El Cajon program fails to inform defendants of the full risks and effects of Antabuse. Further, the authors maintain that the program uses the threat of a jail sentence to coerce defendants into consenting to Antabuse therapy. The authors conclude that defendants' consent is so tainted by these factors that the program amounts to involuntary treatment.

Consequently, the authors suggest that the El Cajon program violates defendants' constitutional right to privacy. Finally, the severity of the Antabuse-alcohol reaction leads the authors to contend that the program constitutes cruel and unusual punishment.

Needell, James E., *Psychiatric Expert Witnesses: Proposals for Change*, Fall 1980, 425-47.

Psychiatric experts are now called more frequently than in the past to testify in courtroom proceedings. Often, however, their testimony leads to non-productive "battles of the experts." This Note examines various plans that seek to minimize the conflicts in expert testimony due, not to legitimate psychiatric disputes, but rather to inaccurate or biased testimony offered by one or both psychiatrists. It concludes that either of two plans would be effective: the first provides for a panel similar to existing medical malpractice tribunals; the second mandates court appointment of an independent expert to testify in addition to those called by adversaries.

Rockey, Paul H., Fantel, Jane, and Omenn, Gilbert S., *Discriminatory Aspects of Pre-employment Screening: Low-Back X-ray Examinations in the Railroad Industry*, Fall 1979, 197-214.

In screening the majority of job applicants, most of this nation's railroads administer a low-back X-ray examination in an attempt to ascertain the likelihood that the applicant will sustain future work-related low-back pain or injury. Many applicants are rejected for employment on the basis of the X-ray findings. The railroads apparently perceive this screening program as a cost-effective means (1) of decreasing the incidence of compensation claims for work-related injuries, brought against the railroads under the Federal Employers' Liability Act (FELA), (2) of reducing the number of lost workdays resulting from low-back pain or injury, and (3) of protecting particularly susceptible workers from job-related hazards.

The authors of this Article submit that low-back X-ray examinations are poor predictors of future low-back pain or injury. They assert that the railroads' use of such examinations misclassifies a substantial number of job applicants as being at increased risk for such pain or injury, and, in consequence, unfairly denies them employment. Furthermore, the authors claim, the screening program has other negative consequences. For example, applicants rejected for railroad employment on the basis of X-ray findings

may as a result have difficulty finding jobs in other industries. In addition, they state, there is a potential radiation hazard to examinees. Moreover, both the railroads and those applicants accepted for employment may inappropriately be reassured by normal findings.

On balance, the authors conclude, the screening program has a negative social value. The authors suggest that the program, in effect, erroneously labels many applicants as handicapped, and then denies them employment. Such persons might have legal recourse under federal and state statutes prohibiting employment discrimination against the handicapped.

Schrero, Elizabeth D., *Patient Compensation Funds: Legislative Responses to the Medical Malpractice Crisis*, Summer 1979, 175-95.

Fifteen states have created Patient Compensation Funds in response to the increased cost and reduced availability of medical malpractice insurance associated with the so-called "medical malpractice crisis." Patient Compensation Fund statutes limit health care providers' liability to a specified amount, and establish state-administered funds to compensate victorious malpractice plaintiffs for damage awards in excess of that amount.

This Note examines the Patient Compensation Fund mechanism, evaluates its effectiveness as a compensation system for malpractice victims, and recommends particular provisions that might enhance its effectiveness. The Note concludes that the Patient Compensation Fund mechanism is an effective means of increasing the availability and of reducing the cost of medical malpractice insurance, and should be adopted by other states experiencing a "medical malpractice crisis."

Shulman, Laurence J., *The Freedom of Information Act and Medical Cost Reports*, Winter 1981, 543-58.

Health care providers must submit cost reports to the Department of Health and Human Services or its designated intermediary before they can be reimbursed for their services by the Medicare system. These reports closely detail the financial operations of the provider. Whenever third parties have requested copies of the cost reports pursuant to the Freedom of Information Act and the Department of Health, Education and Welfare (now HHS) has declared its intention to comply with the request, the providers have sued to enjoin disclosure.

This Note evaluates whether the cost reports are confidential and therefore exempt from mandatory disclosure under Exemption 4 of the Freedom of Information Act. It concludes that they should not be exempt, but that even if they are, disclosure is mandated by a validly promulgated HEW regulation. This regulation was enacted in compliance with the Administrative Procedure Act, and should not be considered an abuse of the HEW Secretary's discretion.

Silbersweig, Susan E., *Payton v. Abbott Laboratories: An Analysis of the Massachusetts DES Class Action Suit*, Summer 1980, 243-82.

In *Payton v. Abbott Laboratories*, U.S. District Court Judge Walter J. Skinner recently granted class certification to an action brought by twenty-seven Massachusetts women against major manufacturers of DES. This is the first case in which a judge has interpreted the requirements of Rule 23 of the Federal Rules of Civil Procedure to allow women exposed *in utero* to DES to sue as a class to determine liability for their injuries.

This Note reviews the *Payton* certification in light of prior class action decisions involving DES and other types of claims, and of legal commentary on Rule 23. This Note contends that Judge Skinner's application of the Rule 23 requirements in *Payton* was procedurally correct, and recommends the class action device as an effective method for litigating such controversies. Finally, this Note analyzes the implications of this landmark ruling for plaintiffs seeking class certification in DES suits and in suits presenting analogous factual situations.

Silfen, Nina P., *Legislative Comment: Nursing Home Patients' Rights in Massachusetts: Current Protection and Recommendations for Improvement*, Summer 1980, 315-33.

Several Massachusetts laws, including the recently enacted Patients' Bill of Rights, protect the rights of nursing home patients. Although these laws address many of the problems that such patients face, they do not adequately meet all of the unique needs of this vulnerable group.

This Comment discusses safeguards afforded by current Massachusetts law that are particularly important for nursing home patients, and recommends improvements that would secure more adequate protection for their rights. The Comment also analyzes some of Massachusetts law's shortcomings in implementation and enforcement, in forum selection, and in limitations on standing, and suggests improvements in these areas. Finally, the Comment proposes the enactment of a comprehensive Bill of Rights for Nursing Home Patients in order to address their unique needs more adequately, and to eliminate the duplicative, vague, and confusing provisions contained in current law.

Shanin, Donald B., *N.L.R.B. v. Baptist Hospital, Inc.: Union Solicitation in Health Care Institutions*, Spring 1980, 105-23.

In 1974, Congress passed the Health Care Amendments to the National Labor Relations Act, thus bringing nonprofit health care institutions within the purview of the Act and within the jurisdiction of the National Labor Relations Board. Since the passage of these Amendments, the Board consistently has held that hospital no-solicitation rules prohibiting employees from engaging in union organizational activities on hospital premises in

other than immediate, patient-care areas are presumptively invalid. In *N.L.R.B. v. Baptist Hospital, Inc.*, 442 U.S. 773 (1979), however, the U.S. Supreme Court questioned the rationality of the Board's presumption, although the Court did not specifically overrule the presumption itself. By examining the special interests arising in the hospital setting, as well as the legislative intent behind the Health Care Amendments, this Note evaluates the Board's presumption in light of the four Supreme Court opinions in *Baptist Hospital*. The Note concludes that the Board's presumption—that hospital no-solicitation rules are invalid in all areas of a hospital except for those areas directly involved in immediate patient care—is rational and reasonable (1) because it properly balances the interests of the hospital, of the employees, and of the patients, and (2) because it is consistent with the legislative intent behind passage of the Health Care Amendments. In addition, this Note contends that the Board has expanded its "immediate patient-care area" standard in an effort to address the Supreme Court's concern in *Baptist Hospital* that the Board's balancing of interests had weighted the patients' well-being too lightly.

Szabo, David S., *Group Life & Health Insurance Co. v. Royal Drug Co.: The McCarran-Ferguson Act and Health Service Plans*, Winter 1980, 393-413.

Until recently, contractual relationships between health care providers and health insurers appeared to be immune from antitrust scrutiny. The Supreme Court ended this apparent immunity in *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), holding that insurance plans offering goods and services to policyholders are not exempted by the McCarran-Ferguson Act from the federal antitrust laws. By denying a McCarran-Ferguson exemption, the Court did not decide the ultimate issue—whether the insurers in fact had violated federal antitrust law.

This Note reviews *Royal Drug* in light of precedent and of the purpose of the McCarran-Ferguson Act. This Note contends that the result in *Royal Drug* follows logically and consistently from the Court's earlier readings of the Act, but that the Court's reasoning is unclear and, even under its strongest reading, unconvincing; hence, an alternative approach to interpreting and applying the McCarran-Ferguson Act is suggested. Finally, this Note analyzes the application of *Royal Drug* by lower federal courts and discusses its implications for the interface of health law and antitrust law.

Tiano, Linda V., *Parham v. J.R.: "Voluntary" Commitment of Minors to Mental Institutions*, Spring 1980, 125-49.

In *Parham v. J.R.*, 442 U.S. 584 (1979), the U.S. Supreme Court held that a parent or a guardian can commit a minor to a mental institution if a staff physician certifies that the minor should be committed, even if the minor strenuously opposes their decision. The Court specifically rejected claims

that commitment of a minor by a parent or guardian without an adversary hearing is a deprivation of the minor's liberty without due process of law. This Note reviews the *Parham* opinion, with special attention to its impact on "mature minors" and wards of the state and to its definition of a neutral factfinder. The Note argues first that the Court's failure to establish special safeguards for "mature minors" and wards of the state is inconsistent with constitutional standards of due process, and second, that the Court's acceptance of staff physicians as neutral factfinders may be unwarranted. The Note recommends the creation of more stringent procedural safeguards for the commitment of minors by parents and guardians, including the use of independent mental health professionals as "neutral factfinders."

Tierney, John T., Waters, William J., and Williams, Donald C., *Controlling Physician Oversupply Through Certificate of Need*, Fall 1980, 335-60.

By 1990 the aggregate supply of physicians in the United States is likely to exceed the population's requirements by 10 percent or more. State and regional aggregate and specialty-specific surpluses may be more extreme. Since the demand for physician services appears to be determined to a significant degree by the supply of physicians, the number of physicians who can maintain financially viable practices in a region is not likely to be limited effectively by the normal market interaction of supply and demand. Excessive physician supplies may, however, have a number of deleterious effects, including rapid escalation of health care costs, fragmentation of patient care, and a decrease in the quality of patient care.

In this Article, the authors review the potential effectiveness of a number of policy interventions that might be employed to optimize physician supplies in areas of excess. They evaluate the following alternatives: (1) a limit on the number of medical school graduates; (2) control of physician residencies by number and by specialty; (3) creation or implementation of incentive policies; (4) control by hospitals—indirectly by limiting the number of beds, or directly by denying staff privileges; (5) widespread development of HMOs; (6) direct employment by the federal government of the majority of practicing physicians; and (7) creation of certificate of need for physician licensure. The authors conclude that, at least in the short term, certificate of need for physician licensure is the alternative that shows the greatest promise of enabling the number and specialties of physicians providing patient care in areas facing a physician surplus to be managed in such a way that the populations of such areas can obtain adequate medical care at a reasonable cost.

Weiner, Stephen M., *Health Care Policy and Politics: Does the Past Tell Us Anything About the Future?*, Winter 1980, 331-41.

The American health care delivery system, and the attitude of the public toward that system, have undergone considerable change during the past

two decades. According to the author, the belief during the 1960s that adequate funds were available to broaden access to health services, to enhance their quality and availability, and to support medical innovation, gave way during the 1970s to an awareness of limited resources, to a skepticism about the motives and competence of established institutions, and to a conviction that the system's problems were too complex to be solved easily, if at all. Moreover, the author states, the system has become fragmented and highly competitive; the respect formerly accorded both professionals and institutions has deteriorated; and the government's role in health care delivery is being challenged.

The result, the author says, may well be a paralysis of policymaking in health planning, as exemplified by the failure of both public and private institutions to achieve the cost-containment goals of the last decade, either through regulation or competition.

To gain perspective on these problems and to determine the direction of the health care delivery system for the 1980s, the author calls for a national health care debate. He suggests four concepts that should be included in such a debate, and recommends a new context of pragmatic idealism in which to conduct it.

White, Anne J., *Tax Policy and Health Maintenance Organizations: The Case for a Section 501(c)(3) Tax Exemption*, Summer 1980, 283-313.

The Internal Revenue Service typically grants health maintenance organizations (HMOs) an I.R.C. section 501(c)(4) exemption from federal income taxation. If these prepayment group medical providers were classified as section 501(c)(3) tax exempt organizations, however, they would receive many additional advantages including increases in private funding and decreases in material and operating costs.

This Note contends that most nonprofit HMOs—whether or not they have qualified under the federal HMO Act—should be granted 501(c)(3) status because they conform with all the specific requisites and general theoretical justifications of a “charitable purpose” tax exempt organization. Specifically, HMOs serve a tax exempt purpose by providing health care, by benefiting the community as a whole, and by relieving the government of some of its public health burdens. HMOs comply with further requirements of section 501(c)(3) and its accompanying I.R.C. regulations by serving a broad membership while avoiding insider control or commercial dealings. Therefore, if an organization is a nonprofit prepayment group practice health provider that serves a broad community and provides health benefits without insider control, it should receive a 501(c)(3) tax exemption.

Zucker, Jay L., *Catastrophic Health Insurance and Cost Containment: Restructuring the Current Health Insurance System*, Spring 1980, 83-103.

Catastrophic health insurance may be necessary to curb rising health care costs in the United States. A major factor in this rise has been the current

structure of the nation's health insurance system, which inadequately protects individuals with expensive illnesses, but encourages over-insurance for less expensive illnesses. This Note examines the current health insurance system, and analyzes its impact on health care costs for individuals and society. It evaluates several proposals to modify the structure of the current health insurance system, and recommends the adoption of a catastrophic health insurance plan based on an economic definition of catastrophe. Such a plan would decrease shallow coverage, and would use coinsurance and deductible rates keyed to the individual's income as means of increasing consumer cost consciousness without making necessary care unreasonably expensive. This Note also recommends that a catastrophic plan only cover treatment that has been determined medically necessary by utilization review, and that this review encourage outpatient rather than costly inpatient treatment.

BOOK REVIEWS BY JAY ALEXANDER GOLD

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